Healthy Communities Initiative (HCI) Assessment of Current City Investments in Public Health
July 7, 2006

Without GF, does Seattle Receive its Fair Share?	Criterion 1: Goal Alignment	Criterion 2: Addresses Need	Criterion 3: Addresses Disparities	Criterion 4: Outcomes	Criterion 5: Sound Practices	Summary Recommendation
Health Care for the Homeless Network (HCHN) (Contractor: Public Health—Seattle & King County)						
Yes – 80% of HCHN services are focused within the city of Seattle. HCHN's expansion grants from the federal government have also benefited Seattle where most of the county's homeless are located.	**Goal 1:** Eliminate disparities – HCHN serves 54% people of color; 48% uninsured; all very low income. **Goal 2:** Promote access – Health providers go to shelters and day centers to serve clients. **Goal 3:** Foster health and well being – HCHN implements health standards and practices. **Goal 4:** Supports ending homelessness – HCHN addresses underlying causes of homelessness; participates in 10-Year Plan; key to the success of supportive housing strategy.	Homeless people experience many health problems that contribute to their homelessness – mental health; substance abuse; acute, chronic conditions; and lack of insurance. The City is represented on the community advisory board that assures than HCHN meets the health needs of the homeless. City-funded services fit into the larger HCHN system.	HCHN serves a disproportionate number of people of color, low income and the uninsured, matching the demographic profile of the city's homeless people. HCHN's outcomes improve the health status and housing stability of the homeless.	HCHN outcomes are measurable and significant for Seattle's homeless population. HCHN outcomes are in two interrelated arenas: improved and more stable 1) health and 2) housing. Without City funding, health and housing outcomes would be impacted negatively: 1,527 fewer people would be served and there would be more than 6,200 fewer health care visits.	**a) Evidence-based/promising practices –** HCHN employs tested, proven strategies including the use of multidisciplinary teams, motivational interviewing and documentation of self-management goals. **b) Culturally competent –** Many HCHN subcontractor staff are people of color and have expertise in working with African-Americans and Native Americans. HCHN sponsors training in racial and ethnic health disparities and in undoing racism. **c) City funding –** Helps to leverage $3+ million federal grant, which requires local funding. **d) Cost effective –** The outcomes and level of service match the City's investments and leveraged funds. **e) Administratively efficient –** City and leveraged funds are significant and program operates efficiently using a network of community providers. Indirect is less than 7% of the total program budget. **f) Track and report outcomes –** HCHN has been exemplary in working with the City to report services and outcomes.	HCHN meets all of the HCI policy framework criteria. As the City, King County and partners implement the Ten-Year Plan to end homelessness, HCHN will be even more important in helping to address the health needs of homeless people. Program Direction: 1. Develop service delivery models and increase capacity to meet the health needs of homeless people in supportive housing. 2. Forge a greater cross-program collaboration with Ryan White Title I HIV/AIDS programs in order to better serve homeless people who have HIV/AIDS. 3. Has secured resources to increase its emergency preparedness efforts working with shelters (particularly on pandemic influenza). 4. Expand the use of self-management goal setting, a best practice.

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Enhanced Tuberculosis Control Services (Contractor: Public Health—Seattle & King County)						
Yes – Over the past three years, about 58% of new active TB cases were in Seattle and about 42% were in King County outside Seattle. About two-thirds of Public Health's efforts were focused on Seattle, given the larger number of homeless and complex cases. The County is funding a satellite TB clinic downtown to better serve the needs of the homeless.	Same as for Health Care for the Homeless, above. Enhanced TB services play a major prevention role in protecting the community (Goal 3) by limiting the spread of TB among the homeless and broader community.	The TB outbreaks over the past several years among the homeless demonstrate the need for enhanced services. These services help assure treatment completion, and therefore, prevention. Program also addresses the housing needs of TB homeless clients.	People of color are disproportionately homeless and at-risk of acquiring TB. One of the recent TB outbreaks affected homeless young men of East African origin.	The enhanced TB services are effective: - 100% of homeless people with active TB complete treatment. - Homeless agency staff have increased knowledge of TB and are able to prevent new cases by promoting healthier environments and referring sympto-matic clients. - All shelters and agencies serving high risk clients partici-pate in ongoing training and support; agency-specific policies are being developed. - Outcomes indicate that housing strate-gies are effective in addressing health and housing needs.	**a) Evidence-based/promising practices –** The enhanced TB services are evidence-based and the program has demonstrated innovation in both its prevention and housing strategies. **b) Culturally competent –** The enhanced TB services have achieved results working with the diverse homeless population. These and other HCHN services are outreach oriented, meaning that services are brought to people where they are rather than waiting for people to come in for services. **c) City funding –** HSD's review of the enhanced TB services determined that City funding is appropriate and needed. The City-funded services are not core regional public health services. **d) Cost effective –** Service level and outcomes match the City's investment. Program generates Medicaid Match that increases the services provided. **e) Administratively efficient –** Contract for enhanced TB services should be combined with the HCHN contract. **f) Track and report outcomes –** The program has worked with the City to improve outcomes tracking and reporting.	The City-funded TB control enhanced services meet all of the HCI policy framework criteria. These services are operated by HCHN and integrated into its network. This TB service component helps the entire HCHN to address the public health threat of TB among the homeless. In 2005, in response to a City Council SLI, HSD conducted a thorough review of this program and found that it was an appropriate City-funded service addressing an important public health need. Program Direction: 1. Administratively integrate HCHN and Enhanced TB services into one contract, reflecting integration. 2. Train and support shelters/other homeless serving agencies in meeting the City's standards for communicable disease prevention including TB guidelines. 3. Connect TB discharge planning functions with the housing and homeless-serving system.

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Pike Clinic Geriatric Nurse (Contractor: Public Health—Seattle & King County)						
Yes – This is an enhanced service that would not be provided without City funding.	As this program is increasingly aligned with Health Care for the Homeless, the same goals apply. In addition, in Goal 4—supports other City goals—this program supports Healthy Aging.	This program targets medically fragile older adults who have a disability and/or a chronic health condition; many are homebound. Predominantly, clients are homeless or formerly homeless and living in supportive hou-sing. The program helps people stay in supportive housing. The program targets three supportive housing sites that have particularly high level of 911 calls and high numbers of resident deaths.	About 40% of clients are people of color. Many have substance abuse issues. A community nurse visits clients in their homes to help them manage their chronic conditions and stay in supportive housing. The nurse links clients with other needed health services including primary care, as well as to other needed treatment and systems. The nurse provides technical assistance, consultation and support for housing staff.	Without City funding, there would be 600 fewer visits to fragile older adults with significant health problems. Many clients would not be able to stay in supportive housing. Program outcomes are to improve health outcomes of medically fragile/ homebound adults. Also, the program works to improve clients' ability to manage chronic health conditions and their skills as tenants. Finally, the program seeks to improve the knowledge of housing program staff to deal with the health needs of residents.	**a) Evidence-based/promising practices –** The community nurse, positioned within Puget Sound Neighborhood Health Center, is now linked to Health Care for the Homeless Network (HCHN). Therefore, she has the infrastructure and support to engage in best practices. **b) Culturally competent –** The community nurse position has been effective in serving clients from diverse cultures, races, and ethnicities. HCHN sponsors training in racial and ethnic health disparities and in undoing racism. **c) City funding –** The nurse position leverages Medicaid administrative match. **d) Cost effective –** The outcomes and level of service match the City's investments and leveraged funds. **e) Administratively efficient –** City funding for this program is $62,000. It should be integrated into HCHN. **f) Track and report outcomes –** We are working with HCHN to propose better outcomes for 2007 in order to report on health outcomes of people in supportive housing.	As the Ten-Year Plan to End Homelessness is implemented, supporting the health needs of people in supportive housing is a fundamental service area that will need to be addressed. This is exactly what this program is working to achieve. This program meets the HCI policy framework criteria. Program Direction: 1. Develop new strategies to support the health needs of people in supportive housing. 2. Integrate program with Health Care for the Homeless. 3. Develop appropriate outcomes for services that address the health needs of formerly homeless people living in supportive housing.

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The Community Health Centers Partnership Program (CHCPP) (Contractor: Public Health—Seattle & King County)						
Yes – The Interlocal Agreement on Public Health between the City and King County specifies that Seattle General Fund will support primary care services for people who reside in Seattle.	**Goal 1:** Eliminate disparities – 83% of patients have incomes below 200% of poverty; 2/3 are people of color; 41% lack health insurance. **Goal 2:** Promote access – Increases access to medical and dental services; helps people to obtain health insurance. **Goal 3:** Foster health and well being – Evidence-based and prevention-based clinical practice models implemented. **Goal 4:** Support other City goals – CHCPP helps assure access to primary care for the homeless. In 2005, CHCPP agencies served 12,603 children and 12,556 seniors.	An increasing number of people lack health insurance – 14 % of all adults in Seattle. 35% of Latino adults lack insurance, as do 21.5% of African-Americans and 20.5% of American Indians/ Alaskan Natives. City funding helps to cover the cost of providing health services to the uninsured. CHCPP includes targeted programs for immigrants/ refugees, older adults, homeless youth, chronic diseases, among others.	- CHCPP increases access for the uninsured, who are disproportionately people of color. - The Center for MultiCultural Health helps immigrants and refugees to access care at all of the Community Health Centers. - A major CHCPP component is Health Care Access, which provides outreach to target groups to enroll them into publicly sponsored health insurance. - CHCPP engages in concerted efforts to improve health outcomes and eliminate disparities.	City funds are necessary to help cover the cost of health care for the uninsured. Without City funds, 9,600 fewer medical visits and 16,500 fewer dental visits would be provided, and many hundreds of people would not access health insurance. CHCPP outcomes exceed the level of City-funding support. Community Health Centers receiving City funding bring in many more resources in order to provide health care for Seattle's low-income and vulnerable populations.	**a) Evidence-based/promising practices –** Services are provided in accordance with nationally recognized best practice standards. **b) Culturally competent –** Access efforts are designed to address disparities. Health Centers have special expertise in serving specific populations including immigrants, refugees, Native Americans/Alaskan Natives, and Latinos. All centers engage in practices and training to provide culturally competent services. **c) City funding –** City funding helps the Community Health Centers survive in a challenging financial environment and helps support the cost of serving the uninsured. City funding leverages Medicaid match to expand outreach/access. **d) Cost effective –** Service levels and outcomes exceed the City's investment and help to leverage other resources. **e) Administratively efficient –** Administrative/overhead costs for overseeing this program have been reduced. The level remaining is justified. **f) Track and report outcomes –** HSD has worked with CHCPP and has developed a plan to improve data reporting to the City.	CHCPP meets all of the HCI policy framework criteria. This program underwent an extensive evaluation in 2003 as a result of a City Council SLI, which led to an RFP process in 2004 that implemented changes in funding for medical, dental and access services. We will conduct another RFI process in 2007 for funding in 2008 and beyond. Program Direction: 1. Improve data and reporting to assure that the City's investments help to address disparities in health outcomes based on race, income, insurance status and neighborhood. 2. Support and report on efforts to address health disparities. 3. Support and report on initiatives to improve the quality of care. 4. CHCs face significant financial challenges due to increasing uninsured and reduced federal funding. 5. Most CHCs are changing to an electronic practice management system to improve quality; may temporarily decrease productivity.

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Access and Outreach (PeoplePoint and Infant Mortality Prevention) (Contractor: Public Health—Seattle & King County)						
Yes – People Point services are only provided within Seattle. In King County outside Seattle, there are no application workers to help people access health insurance and other public benefits. For Infant Mortality Prevention, 8 agencies provide services to Seattle residents; only 4 with City funds.	**Goal 1:** Eliminate disparities – Targets African-Americans, Native Americans, Latinos, immigrants/ refugees, and homeless people. Increases access to health insurance and care. **Goal 2:** Promote access – Increases access to health insurance and care. **Goal 3:** Foster health and well being – Promotes community health through outreach, early screening, and community supports to ameliorate impact of racism on pregnancy outcomes. **Goal 4:** Support other City goals – Assists families to find/keep housing.	- An increasing number of people lack health insurance (see previous section). Program conducts outreach and enrollment into publicly-sponsored health insurance. - Infant mortality rates are higher for African-Americans and Native Americans. Program provides outreach, education and case management to improve pregnancy outcomes.	There are two program components; both address disparities: <u>PeoplePoint</u> (formerly called Help for Working Families) links people with health insurance and other public benefits (child care, food, utility assistance, tax assistance). <u>Infant Mortality Prevention</u> Community-based organizations provide services to improve pregnancy outcomes; focus on African-Americans and Native Americans.	Without City funding, 600 people would not be linked to health coverage and 300+ would not access other public benefits. The program provides health education to 3,750 people and helps 105 high-risk women of childbearing age access prenatal care, health services and other resources. (The Center for Multi-Cultural Health, Operational Emergency Center, Intra African Connections and United Indians of All Tribes provide services without City funding.)	**a) Evidence-based/promising practices –** Community-based outreach is effective in reaching minority and non-English speaking people. Health insurance helps to increase access. Program has been effective in helping high-risk pregnant women access prenatal care and other services. **b) Culturally competent –** Subcontracts with community organizations (El Centro de la Raza, People of Color Against AIDS Network, Seattle Indian Health Board, Street Outreach Services); services are targeted to reach people of color. **c) City funding –** City funding leverages $575,000 in Medicaid match/other funding. The City purchases services that are not available in the county outside Seattle. **d) Cost effective –** Cost effective consid-ering the value of the outcomes: access to health insurance/other benefits for 900+ clients, and infant mortality prevention. **e) Administratively efficient –** The City's investment is significant and yields commensurate outcomes. **f) Track and report outcomes –** The program reports the # of people who access public benefits and the # of high-risk pregnant women who access services.	Access and Outreach encompasses two programs: PeoplePoint (a City initiative helping people to access public benefits, formerly called Help for Working Families) and Infant Mortality Prevention. The latter program subcontracts with People of Color Against AIDS Network, Seattle Indian Health Board, Street Outreach Services, and El Centro de la Raza. The Access and Outreach programs meet all of the HCI policy framework criteria, and address significant needs and disparities. Programs are aligned with City goals. Program Direction: 1. Increase the number of people accessing other public benefits (child, care, utility assistance, food assistance, tax assistance) as well as health insurance. 2. Improve reporting on services to high-risk pregnant women and on pregnancy and birth outcomes.

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Best Beginnings / Nurse Family Partnership (Contractor: Public Health—Seattle & King County)						
Yes – This is an enhanced service only provided when non-core regional public health funds are specifically available to operate the program. City GF represents 45% of overall program revenues, including Medicaid Administrative Match, FQHC, and Title XIX Maternity Support.	**Goal 1:** Eliminate disparities – Best Beginnings is a tested, effective program that improves prenatal health and birth outcomes; reduces the number of subsequent pregnancies, and has long-term benefits for first time pregnant/ parenting teen mothers and children. Program serves 90% low-income, 55% minority. **Goal 2**: Program promotes access to all needed clinical and preventive services. **Goal 4:** Support other City goals **–** proven long-term benefits include improved school readiness, higher educational attainment, stable housing, etc.	Teen mothers are significantly more likely to get little/ no prenatal care, and have low birth weight and premature babies. First-time, high-risk, low-income teen moms need support to improve the long-term prospects for themselves and their child.	There are significant disparities in infant mortality in African-American and Native American populations. Although teen birth rates are declining overall, the birth rate among Latina teens is increasing, and the rates for African-American and Native American adolescents are higher than for Whites and Asian/Pacific Islanders. Best Beginnings addresses disparities based on income and race.	Without City support, 169 pregnant and parenting teens would not be served. Gains in healthier births, improved immunizations, decreased child abuse and neglect would not occur. The outcomes achieved locally have met or exceeded national results. Program has undergone longitudinal studies that have documented long-term benefits. In addition to other outcomes, the program reports on the progress that teen mothers make in school, training, and work.	**a) Evidence-based/promising practices –** Best Beginnings is local replication of the national Nurse Family Partnership, the most rigorously tested program of its kind. **b) Culturally competent –** Demonstrates effectiveness in serving African-American, Native American, and Latina adolescents. **c) City funding –** Without City funding program would not operate in Seattle; City funds leverage $575,000 in additional revenues. **d) Cost effective –** Cost benefit studies on the Nurse Family Partnership have estimated that this program saves as much as $17,000 for every family served. Program costs are recovered by the time the first child reaches 4 years of age. Cost savings include crime reduction, improved educational outcomes, prevention of substance abuse, prevention of child abuse and neglect, and reduction of teen pregnancies and public assistance. **e) Administratively efficient –** The City's investment is significant and yields commensurate results. **f) Track and report outcomes –** Best Beginnings tracks and regularly reports program outcomes to the City.	Best Beginnings meets all of the HCI policy framework criteria. It serves a high-risk population, addresses disparities, and achieves excellent outcomes. This proven program helps promote school readiness and has lifelong benefits for mother and child. Program Direction: 1. Develop capacity to backfill Best Beginning nurses who are on leave in order to maintain maximum caseload in a way that retains fidelity to the program model. This must be balanced with the cost of training. 2. Bring in additional funding to serve more high-risk pregnant and parenting teens including expanded capacity to serve immigrants/ refugees. 3. Enroll young women as early in pregnancy as possible to maximize program impact and outcomes.

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HIV/AIDS Case Management (Contractor: Public Health—Seattle & King County)						
Yes – 84% of persons living with HIV/ AIDS (PLWH) who receive case management services are Seattle residents. Seattle clients have higher acuity levels than clients in the rest of the county. Seattle receives its fair share of services and benefits from a countywide approach in addressing HIV/AIDS.	This program is most aligned with **Goal 2:** it promotes access to clinical and preventive health services. Case management services increase access to a wide variety of services associated with improved clinical outcomes. This program also addresses Goal 1 (disparities) by assuring case management services to the increasing number of PLWH who are of color and low income. This program also addresses Goal 4 by providing case management services for PLWH who are homeless.	Public Health data identify: - HIV/AIDS as a significant problem in Seattle as compared to the rest of the county. - HIV/AIDS as one of the few health indicator trends that is going in an adverse direction for Seattle and King County. - Disparities in AIDS deaths by race. - Disparities in HIV and AIDS prevalence and incidence by income.	41% of HIV/AIDS Case Management clients receiving case management services are people of color, compared with 25% of the population, reflecting the higher rate of HIV/AIDS among people of color. The HIV/AIDS program is working to serve people where the epidemic is emerging (African immigrants, Latinos, and African-Americans).	Without City funding, there would be waitlists for PLWH who want case management. Also, caseloads, already averaging almost 80 clients per case manager, would increase. The program has recently changed from reporting the number of case management contacts to reporting the number of referrals and successful linkages to primary care, prescription drug programs, mental health, substance abuse treatment, dental care, health insurance, and housing.	**a) Evidence-based/promising practices –** Case management for PLWH has been shown to prevent unnecessary hospitalizations and expedite discharge from in-patient facilities. Also, PLWH with case managers are significantly more likely to adhere to their medication regimens and have decreased unmet needs. **b) Culturally competent –** Case Management staff reflect populations served. Targeted outreach effective in getting people into case management/care. **c) City funding –** City funding helps to leverage Ryan White funds and Medicaid Title XIX match. City funding is especially crucial given pending changes in the Ryan White CARE Act reauthorization. **d) Cost effective –** Very cost effective considering the cost of hospitalizations and more costly care that the program prevents. **e) Administratively efficient –** Only 6% of City funds are used for oversight and performance monitoring. Program yields good outcomes and results. **f) Track and report outcomes –** At the City's request, the program has been very responsive in changing to outcomes reporting.	HIV/AIDS case management assures clients an appropriate level of care and access to services. It is cost effective. It meets the HCI policy framework criteria. Changes in the Ryan White CARE Act reauthorization could result in a significant decrease in case management and support services available to PLWH. City funding of case management will be even more important as the number of PLWH increases as does the acuity of their needs (increases in incarceration, substance abuse, mental illness, and homelessness). Program Direction: 1. Has changed to outcomes-based reporting (referrals and linkages). 2. Working to assure that case management services are culturally appropriate in serving populations where the epidemic is emerging including African immigrants, Latinos and African-Americans. 3. Working to meet the multiple and complex needs of clients.

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The Northwest Family Center (NWFC) (Perinatal HIV Consortium) (Contractor: Public Health—Seattle & King County)						
Yes – NWFC serves about 60% women and families who reside in Seattle, about one-third of whom are homeless. Most of the program's health and support services are located in Seattle.	NWFC is most aligned with **Goal 2:** it promotes access to clinical and preventive health services. Case management increases access to a wide variety of services associated with improved clinical outcomes. NWFC also addresses Goal 1 (disparities) by assuring case management services for women and children of color. NWFC also addresses Goal 4 by providing case management services for women and children with HIV/AIDS who are homeless.	HIV/AIDS disproportionately affects Seattleites compared to the rest of King County. HIV/AIDS disproportionately affects women and children of color and who are low income. There is a high rate of mental illness (30%) and chemical dependency (66%) among NWFC clients.	59% of NWFC clients are women and children of color, compared with 25% of the general population. Almost 100% have incomes less than 200% of poverty. In order to meet the needs of its clients, NWFC works cooperatively with the UW Medical Center, Children's Regional Medical Center, and Harborview. NWFC is co-located where clients receive primary care and where pregnant women and their infants receive HIV care.	For more than 11 years, no infant born to an HIV + women cared for by NWFC has been HIV +. NWFC has moved to the same outcomes reporting as has HIV/AIDS Case Management. NWFC is reporting referrals and successful linkages to primary care, prescription drug programs, mental health, substance abuse, dental care, health insurance, and housing. Because leveraging is required, Ryan White and Medicaid match funding would be jeopardized if City funding ended.	**a) Evidence-based/promising practices –** Same as for HIV/AIDS Case Management Program above. Also, NWFC practice helps assure that HIV is not transmitted between mother and child. **b) Culturally competent –** Program outcomes for the 59% of clients who are of color are comparable with outcomes for Euro-American clients. **c) City funding –** City funding helps to leverage Ryan White funds and Medicaid Title XIX match. Loss of City funding could negatively impact service levels. **d) Cost effective –** Very cost effective considering the prevention of transmission of HIV from mother to child, and the cost of hospitalizations and more costly care that the program prevents. **e) Administratively efficient –** City funding is $30,207 of NWFC's $771,000 budget. It is not particularly efficient to manage this contract, but City funding is important to keep NWFC services intact. **f) Track and report outcomes –** At the City's request, the program has been very responsive in changing to outcomes reporting.	NWFC's goal is to optimize the health and well-being of HIV infected women, children and youth and their families through case management and linkage to services which enables clients to better manage their care and their lives. NWFC meets the HCI Policy Framework criteria except it is not administratively efficient due to the small amount of City funding. Program Direction: 1. Has changed to outcomes-based reporting (referrals and linkages). 2. NWFC is a special component of HIV/AIDS case management that focuses on women/children/youth and their families. Administra-tively, HSD should combine the City's NWFC funding with HIV/AIDS Case Management funding. The City would still require that a designated amount of funds would go to NWFC and continue to track NWFC outcomes. 3. Is struggling to maintain service levels given flat federal funding that doesn't keep up with costs.

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Seattle Needle Exchange (SNE) (Contractor: Public Health—Seattle & King County)						
Yes – 96% of the needle exchanges and 99% of the client visits occur within Seattle. Six of the seven exchange locations are in Seattle and 90% of the clients are Seattle residents. Higher per capita rates of illicit drug use occur in the urban core of large metropolitan areas.	**Goal 1:** Eliminate disparities – Injection drug use (IDU) is disproportionately associated with race, income, health insurance status, and neighborhood. **Goal 2:** The program promotes access to preventive and clinical health services including methadone vouchers, case management, social services, wound and abscess care, HIV/ TB/STDs/hepatitis screening/treatment, and primary care. **Goal 3:** The program protects physical environments and the community through safe disposal of items that are contaminated with blood borne pathogens.	SNE exchanges 1.8 million syringes in 50,000 encounters annually. Easy access to sterile syringes and equipment significantly reduces the acquisition and transmission of blood borne pathogens (e.g. HIV, hepatitis). Reduces morbidity and mortality associated with injecting unregulated drugs. Links ID users to methadone treatment.	SNE has been effective in protecting ID users and their partners from HIV transmission. Both ID users and their partners are disproportionately low income and people of color. SNE should be credited with the low rate of HIV among women and the very low rate of perinatal HIV cases in the Seattle area. In fact, in Seattle, not a single child has been born with HIV since 1997.	The program keeps HIV prevalence among ID users low (3-4%) compared to other major cities without needle exchange programs that have HIV rates of 20%-50%. Without City funds, services would be reduced significantly. Since 90%+ of all services are focused on Seattle, Seattle ID users would be greatly impacted. Indigent and marginalized opiate dependent people would share and re-use injection equipment and there would be an increase of HIV among ID users, their sexual partners and families.	**a) Evidence-based/promising practices –** Research is clear that needle exchange programs reduce the spread of HIV and other infectious diseases without increasing drug use. These programs reduce illegal drug use and link ID users to services such as TB, HIV, and STD treatment, drug treatment and entitlements such as Medicaid and SSI. Cities without needle exchange experience a 5.9% increase in HIV incidence per year. **b) Culturally competent –** The program reaches and serves the target population. **c) City funding –** City funding is critical to maintaining this service. Loss of City funds couldn't be made up from other sources and would reduce service levels. **d) Cost effective –** Very cost effective considering program effectiveness in preventing transmission of HIV and other blood borne pathogens. **e) Administratively efficient –** City funding is significant to program operation and yields commensurate results. **f) Track and report outcomes –** At the City's request, the program has been very responsive in changing to outcomes reporting.	SNE meets all of the HCI Policy Framework criteria. It is an enhanced service justified by data with a program design based on research. The result: low HIV prevalence rates among ID users and their sexual partners. Program Direction: 1. The downtown needle exchange site will have to move during the coming year. It is critically important that needle exchange services be maintained in the greater downtown area. It will be very challenging finding a suitable location. 2. A suitable new location will allow the program to seek other funding to expand wrap around services such as case management, support for treatment access, and wound care. Currently, these services are limited by lack of space at the present downtown storefront location.

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Methadone Treatment/Vouchers (Contractor: Public Health—Seattle & King County)						
Yes – Seattle residents are proportionately accessing methadone treatment funded by non-City sources. City funding brings us closer to treatment-on-demand, reduces the waitlist, and provides better access to treatment for Seattle Needle Exchange (SNE) clients and people who commit crimes.	**Goal 1:** Eliminate disparities – The adverse effects of opiate dependency disproportionately impact communities of color, low-income and uninsured populations, and several Seattle neighborhoods. **Goal 2:** Promote access – In addition to greater availability of methadone treatment, case manager facilitates Medicaid linkage and access to clinical and preventive health services for the uninsured. **Goal 3:** Foster health and well being – Opiate dependent people stabilize their addiction, stabilize their housing, and withdraw from cyclical criminal activity.	Opiate addiction is a medical condition that needs ongoing treatment to restore patients' abilities to function and avoid criminal activity. Unmet need for methadone treatment is well documented by the waitlist for treatment maintained by SNE staff. Opiate replacement treatment with methadone is the best choice of treatment, which is well documented in the medical literature.	In 2005, 50% of the clients served were people of color. Opiate addiction disproportionately impacts racial and ethnic minorities. The Methadone Treatment program effectively reaches the target population largely through SNE sites, where staff members establish relationships of trust that create occasions for informing and supporting clients to enter treatment.	This program assures that more opiate addicted Seattleites will be able to enter methadone treatment, and do so more quickly: - SNE clients - Referrals from Municipal Court can access services immediately - Interim/emergency funding to keep clients stabilized in treatment while longer-term funding can be secured. Without City funding, waitlists would increase by 50%. More people would experience the numerous medical, social and legal problems associated with illegal drug use.	**a) Evidence-based/promising practices –** Research shows that Methadone treatment reduces crime, enhances social productivity, and is effective in preventing HIV because people engage in less risky behaviors. The length of time people stay in treatment correlates with better outcomes. Staying in treatment one year or longer reduces health related costs by $899 per person per month. **b) Culturally competent –** The program reaches and serves the target population, mitigating many social and legal problems. **c) City funding –** City funding helps assure that people will get into treatment sooner and will not have a break in treatment. **d) Cost effective –** Cost effective considering program effectiveness in preventing transmission of HIV and mitigating negative consequences of opiate use. **e) Administratively efficient –** 94% of the funds are for subcontracts to purchase treatment months. **f) Track and report outcomes –** At the City's request, the program is exploring if it can track how long clients remain in treatment. Many clients transfer to other fund sources, making tracking difficult.	The program meets the HCI policy framework criteria. City funding helps to shorten the waitlist and gets people into treatment when they are ready for treatment. It is a 'companion' program with SNE, offering SNE clients the opportunity for treatment. Program Direction: 1. Explore creating a system to track length of time clients who are transferred to other funding sources remain in treatment. Length of time in treatment is an important marker of success. 2. Continues to work with King County, Washington State, the King County Bar Association, and others to expand funding for drug treatment at the State level. 3. Plans to apply for private funding from the George Soros-sponsored Open Society Institute (OSI) to further reduce the waitlist. Seattle's program was featured at the recent OSI-sponsored drug policy conference.

Without GF, does Seattle Receive its Fair Share?	Criterion 1: Goal Alignment	Criterion 2: Addresses Need	Criterion 3: Addresses Disparities	Criterion 4: Outcomes	Criterion 5: Sound Practices	Summary Recommendation
Indoor Air Quality Program (Improved Respiratory Health) (Contractor: Public Health—Seattle & King County)						
Yes – This program only operates in Seattle. In the recent past, Public Health has received several large multi-year grants focused on asthma. Interventions have been targeted to Central and South Seattle neighborhoods with higher rates of asthma and children hospitalizations for asthma.	**Goal 1:** Eliminate disparities – There are disparities in asthma hospitalizations based on race, income, and neighborhood. This program is focused on improving indoor air quality in low-income neighborhoods. **Goal 3:** Foster health and well being – The program protects from environmental hazards (poor indoor air quality); provides a community level response; and informs City policy, regulations, and enforcement.	Children in Seattle are significantly more likely to be hospitalized for asthma than children elsewhere in the county. There are many large rental housing complexes that have poor indoor air quality because regulations are inadequate, not enforced, or ventilation systems do not function. This housing primarily serves low- to moderate- income people. The result is poor indoor air quality, which exacerbates respiratory problems.	The program's work is focused on building complexes in neighborhoods with high asthma rates. It has a coherent strategy to improve indoor air quality: - Change individual behaviors through education. - Make structural changes through community outreach and assistance. - Make systemic changes by informing policy, regulation, and enforcement.	The program's outcomes are to improve indoor air quality and respiratory health. Strategies focus on resolving indoor air quality problems. HSD has worked with Public Health to revamp this program to encompass a more community-level approach. The program changed to be aligned with the work of the City's Indoor Air Quality Interdepartmental Team. The program will address and resolve indoor air quality problems at low-income housing complexes.	**a) Evidence-based/promising practices –** Research shows that there is a direct correlation between home environmental conditions and the well being of children with asthma. The program utilizes interventions that research shows are effective in both improving indoor air quality and respiratory health. **b) Culturally competent –** The program is focused on low-income people and people of color. Interventions are designed to engage people in community level education and organizing to resolve indoor air quality problems. **c) City funding –** City funds represent 89% of the program's funds. **d) Cost effective –** Costs are reasonable. HSD will evaluate the results of this new approach in light of the costs. **e) Administratively efficient –** Investment is relatively small ($56,727); 88% of program funds are used to pay for the cost of the staff person providing the service. **f) Track and report outcomes –** The program has changed to now report outcome data on resolution of indoor air quality problems in low-income housing units.	This program changed significantly in 2006 to be aligned with the work of the City's Indoor Air Quality Interdepartmental Team. HSD will assess the effectiveness of this new, more comprehensive and systemic approach. The program meets the HCI Policy Framework criteria. Program Direction: 1. Assess effectiveness of the program changes. 2. Continue to align work with City Indoor Air Quality Interdepartmental Team. 3. Consider combining the funds from this project and the American Lung Association's Master Home Environmentalist Program and conduct an RFI process.

Without GF, does Seattle Receive its Fair Share?	Criterion 1: Goal Alignment	Criterion 2: Addresses Need	Criterion 3: Addresses Disparities	Criterion 4: Outcomes	Criterion 5: Sound Practices	Summary Recommendation
Community Based Oral Health Program (Sealants) (Contractor: Public Health—Seattle & King County)						
Yes – The investment of GF means that more schools, sites, and children in Seattle are able to be served. Needs data indicate that one-third to 40% of program activities should be focused in Seattle. The program serves 32 schools in Seattle and 26 in the rest of the county. Also, the program serves children at high need child care and community-based sites only in Seattle.	**Goal 1:** Children who are low-income, of color, and who are immigrants/refugees disproportionately experience dental disease. The program focuses on these populations. **Goal 2:** The program promotes access to clinical and prevention services by applying sealants to the first permanent molars of children—at their schools. **Goal 3:** The applied sealants prevent decay and promote oral health. **Goal 4:** The City is developing strategies to serve refugees and immigrants better. A primary focus of this program is on serving immigrants/refugees.	Key findings from the 2005 Smile Survey for Seattle and King County: - Low-income children are at least twice as likely to have untreated dental disease. - Children of color are at least twice as likely to have untreated dental disease. - Preschool children of color are at higher risk for caries. - Students whose primary language is not English are twice as likely to have untreated dental disease.	The program serves children at schools with a large proportion of students on free/ reduced lunch (a proxy for low-income) and English language learners. By applying sealants, dental decay is prevented. Also, children at Childhaven, Seattle Housing Authority child care centers, schools with high numbers of English language learners, and other high-risk sites will be screened and referred to services.	Dental disease is the most prevalent chronic disease in children, affecting eating, sleeping, and learning. By applying sealants to the molars of children needing them, dental disease is prevented. 950 children will experience less dental disease due to the application of sealants. The program's one-year sealant retention rate is 90%+. Without GF support, students in at least ten Seattle schools and 300 children in child care and community-based sites would not be served.	**a) Evidence-based/promising practices –** Sealants are an evidence-based prevention strategy that has been recommended by Healthy People 2010. Analysis of the Smile data indicates that children in schools with the sealant program experience significantly higher rates of dental sealants that prevent disease. **b) Culturally competent –** The program effectively targets children who are low-income, immigrants/refugees, and of color, as well as homeless children. An analysis of the Smile Survey and program data indicates that services are targeted appropriately. **c) City funding –** City funding represents 16% of total budget, helps to leverage other funds, and buys a greater service levels. **d) Cost effective –** Costs are commensurate with results. Sealants prevent dental disease. **e) Administratively efficient –** Relatively small investment yields good results. **f) Track and report outcomes –** The program reports on the number of children, screened, referred to services, the number who have dental sealants applied, and the number of sealants retained after one year.	The program meets the HCI policy framework criteria. The program focuses on populations that disproportionately experience dental disease: children of color, low-income children, and immigrant/refugee children. Sealants are a primary prevention strategy proven to prevent dental disease. Program Direction: 1. Align program services with City-funded child care centers serving high-risk children. Program can screen and refer children, and help them to find a dental home. 2. Most of the Seattle public elementary schools slated to be closed has sealant programs. The program will work with the school district to reach the high-risk populations. 3. When program staff identifies children with dental disease, they refer them for treatment. The program is working on effective strategies to connect children with ongoing dental homes.

Without GF, does Seattle Receive its Fair Share?	Criterion 1: Goal Alignment	Criterion 2: Addresses Need	Criterion 3: Addresses Disparities	Criterion 4: Outcomes	Criterion 5: Sound Practices	Summary Recommendation
Chemical Dependency Interventions for High Utilizers at Harborview Psychiatric Emergency Services (Contractor: King County Department of Community and Human Services)						
Yes – This is an enhanced service providing access to chemical dependency (CD) screening, assessment and treatment, as well as referral to other services. The target population is high utilizers of the Harborview Psychiatric Emergency Services, most of whom are chronically homeless people.	**Goal 2:** Promote access – homeless clients in crisis are stabilized and able to access CD screening, assessment, detoxification, and treatment. Next day CD appointments are available. Clients are referred to other services, including mental health and developmental disabilities. **Goal 4:** 90% of the clients served are homeless. The program is working to address the needs of chronically homeless people who are frequent utilizers of Harborview Psychiatric Emergency Services.	In society and among homeless people, abuse and addiction to alcohol/other drugs is well documented. There are approximately 250 drug-related deaths in King County and 2,000 Harborview Emergency Services drug-related reports annually. The program provides screening on demand/as needed, detoxification, assessment, and treatment services including next day appointments.	100% of people served are in crisis and exhibit behaviors that require screening. 90% of the clients are homeless. A higher proportion of clients are people of color than are represented in the general population including many Native Americans. The needs of clients are served by providing ready access to CD screening and treatment and by linking chronic homeless people to other services.	Without City funding, 950 individuals would not be screened and 224 would not receive next day appointments. City funding provides the staff and mechanism to connect high utilizers/chronically homeless people with services and to make screening and treatment readily available. Please note that the CD treatment services are publicly funded and not paid for by the City, nor included in the City's contract. Clients are connected with into ongoing treatment as quickly as possible.	**a) Evidence-based/promising practices –** Providing screening and ready access to treatment is effective in helping people enter and participate in CD treatment. **b) Culturally competent –** The program is effective in helping homeless people who are in crisis, due at least in part to their substance abuse, to stabilize and enter treatment. **c) City funding –** City funding is critical and without it, these services would not be provided. The County funds 25% of this program, plus provides the state dollars that pay for the CD treatment services. The City, in essence, helps leverage the treatment funds. **d) Cost effective –** Costs are reasonable and include 10% for administration. **e) Administratively efficient –** City funding is essential, administrative costs are reasonable, and contracted outcomes justify the expense. **f) Track and report outcomes –** King County is working with HSD to change the outcomes that it tracks and reports.	This program used to be called the Crisis Triage Unit (CTU); however, when state mental health funding decreased, CTU ceased to exist. The program is now a partnership between King County, Harborview and the City focused on providing CD services for high utilizers of Harborview Emergency Psychiatric Services, and helping them to access other services that will move them out of homelessness. This program meets the HCI policy framework criteria. Program Direction: 1. Convene regular high utilizer case staffing meetings to identify strategies to better serve chronic homeless clients. 2. King County, Harborview and the City each have appointed a lead staff person who will foster exchange of information, increased communications, and increased cooperation to improve the program's ability to serve high utilizers/chronic homeless and connect them to services.

Without GF, does Seattle Receive its Fair Share?	Criterion 1: Goal Alignment	Criterion 2: Addresses Need	Criterion 3: Addresses Disparities	Criterion 4: Outcomes	Criterion 5: Sound Practices	Summary Recommendation
Emergency Services Patrol (ESP) (Contractor: King County Department of Community and Human Services)						
Yes – This is not a core regional public health service. It is an enhanced service available only in the greater downtown area to address the problem of chronic public inebriants and intoxicated or incapacitated individuals, about 98% of whom are homeless.	**Goal 2:** The program promotes access to health services by providing screening and immediate transport to needed services, including to detoxification services, the sobering center, and Harborview. **Goal 3:** The program promotes safe environments. It protects both intoxicated individuals and the broader public. It frees police and fire personnel to respond to other emergencies. **Goal 4:** The program is aligned to ending homelessness by addressing the needs of the chronically homeless in downtown Seattle.	In society and among the homeless, abuse and addiction to alcohol/other drugs is well documented. There are approximately 250 drug-related deaths in King County annually. ESP transports 13,200 individuals annually to services. 700 in-person responses are provided in situations where police or fire personnel would have to respond and remain at the scene; thus, ESP frees them to respond to other emergencies.	100% of people served by ESP are in crisis and exhibit behaviors that need additional screening. More than 98% of the clients are homeless. A higher proportion of clients are people of color than are represented in the general population. Approximately 30% of clients served are Native Americans.	The program has clear outcomes, providing screening and transportation to needed services to 13,200 (duplicated) clients. In addition, ESP frees police and fire personnel to tend to more pressing matters in approximately 700 'incidents.' Without City funding, ESP services would be in jeopardy. The City funds less than one-third the cost for ESP, with King County Current Expense providing $150,000 more than the City's contribution.	**a) Evidence-based/promising practices –** ESP receives high marks from the City of Seattle Police Department, King County chemical dependency treatment services, Harborview, and other first responders. **b) Culturally competent –** ESP effectively serves the homeless, who are disproportionately people of color. **c) City funding –** The City provides $478,000 in funding, 31% of the total. This is a partnership with King County, which contributes 40% of the total. (The rest is from federal/state sources.) **d) Cost effective –** Costs reflect actual operating costs plus 10% for administration. Rising fuel and personnel costs could translate to reduced hours of operation if revenues are flat. **e) Administratively efficient –** City funding is significant to ESP operations and yields commensurate results. **f) Track and report outcomes –** ESP is working with the City to improve reporting. It provides information on meeting contracted outcomes of trips including cases where police and fire personnel are freed to address other pressing needs due to ESP intervention.	ESP meets all of the criteria in the HCI policy framework and provides an important service. In 2005, the City reduced its funding for ESP, which resulted in the discontinuation of transportation services between 8:00 AM – Noon on a daily basis. The Seattle Police Department highly values ESP services since it frees police to handle other emergencies. Program Direction: 1. ESP and Health Care for the Homeless are exploring how to connect case management and proactive outreach with ESP transporting services. The model is from the City of Philadelphia where outreach teams respond to calls and outreach to homeless people on the streets, helping to connect them to shelters and services. 2. ESP is exploring how it can restore services on a 24 hours/seven days per week basis.

Without GF, does Seattle Receive its Fair Share?	Criterion 1: Goal Alignment	Criterion 2: Addresses Need	Criterion 3: Addresses Disparities	Criterion 4: Outcomes	Criterion 5: Sound Practices	Summary Recommendation
Youth Engagement Program (YEP) (Contractor: King County Department of Community and Human Services)						
Yes – This is an enhanced service (outreach and engagement to link high-risk youth to substance abuse treatment) not provided outside Seattle. $84,378 of the $239,939 GF supports the Multi-Systemic Therapy Program for court-involved youth, part of Reinvesting in Youth and Reclaiming Futures, in which the City, King County, and Superior Court are partners.	**Goal 1:** YEP targets youth of color and sexual minorities who are involved with drugs or alcohol and/or the juvenile justice system, and engage in risky behaviors. YEP engages youth in their own neighborhoods on their own terms. **Goal 2:** The primary outcome is to link youth to chemical dependency treatment and other services. **Goal 4:** Another important outcome of the program is to increase youth's engagement with and success in school and in work. This supports the City goal of closing the academic achievement gap.	Many youth abuse or are addicted to alcohol and other drugs. Without culturally appropriate outreach, engagement and case management services, many youth would not enter treatment. Through subcontracts, YEP provides outreach, intervention, screening, assessment, and admission into treatment on demand. YEP services are critical to getting youth into treatment and to helping them set and achieve goals.	YEP subcontracts with three community-based providers for treatment, outreach, engagement and case management services for low-income youth: - Central Area Youth and Family Services, serving African American youth in the Central District and Rainier Valley. - Seattle Counseling Services, serving sexual minority youth with a focus on homeless youth. - United Indians of All Tribes, serving Native American youth.	For the 2006 contract, HSD worked with King County to revamp the outcomes reported to the City. The program now reports the number of youth who participate in chemical dependency treatment. Also, YEP now works with youth to set treatment, school, and life skill goals and develop written plans. Goals relate to school, work, justice system obligations, and reduction of risky behaviors including drugs and alcohol. Without City funding, 180 youth would not engage in treatment and 360 would not achieve their goals.	**a) Evidence-based/promising practices –** The literature indicates that outreach and engagement activities are necessary and effective to engage youth in treatment services. New outcome reporting will help measure the effectiveness of YEP. **b) Culturally competent –** Subcontractors were chosen because of their cultural competence in working with youth who are African-American, Native American, and sexual minorities. **c) City funding –** Without City funding, these services would not be provided. King County provides nearly 25% of the total funding, which does **not** include the cost of the chemical dependency treatment, which is covered primarily by state funds. **d) Cost effective –** Costs are reasonable, negotiated with subcontractors, and include 10% for administration. **e) Administratively efficient –** City funding is essential, administrative costs are reasonable, and contracted outcomes justify the expense. **f) Track and report outcomes –** King County has worked with HSD to revamp its tracking and reporting of outcomes.	YEP meets all of the criteria in the HCI policy framework criteria. It is also now aligned to support the City's goal of closing the academic achievement gap. Changes in reporting outcomes will help determine the effectiveness of the program in getting youth into treatment and in achieving academic and other goals. Program Direction: 1. YEP has changed the outcomes that it is reporting, which will be used to assess program effectiveness. 2. HSD is considering conducting an RFI process to choose providers. In order to achieve the best outcomes, the City should assure that the program is optimally aligned with other City-funded programs such as youth mental health and Families and Education school-based health services.

Without GF, does Seattle Receive its Fair Share?	Criterion 1: Goal Alignment	Criterion 2: Addresses Need	Criterion 3: Addresses Disparities	Criterion 4: Outcomes	Criterion 5: Sound Practices	Summary Recommendation
Master Home Environmentalist (MHE) Program (Contractor: American Lung Association of Washington [ALAWA])						
Yes – MHE is an enhanced service offered countywide by ALAWA. Most (at least 70 % to 75%) of the services are focused on Seattle, in part, because of the City funding.	**Goal 1:** Eliminate disparities – HSD has worked with ALAWA to target MHE services to neighborhoods that have higher rates of children hospitalized for asthma, which also have higher proportions of low income families and people of color. **Goal 3:** Foster health and well being – MHE promotes healthy environments free of environmental hazards. **Goal 4:** Support other City goals – By helping to make homes healthier places to live, MHE supports other City goals such as healthy aging.	Children in Seattle are significantly more likely to be hospitalized for asthma than children elsewhere in the county. According to the EPA, people spend 90% of the time indoors. MHE volunteers and CLEARCorp (CC) members identify asthma triggers in the home and educate people on how to eliminate/reduce them. They also conduct community education events.	There are disparities based on race, income and neighborhood in asthma prevalence, incidence and hospitalization rates. ALAWA is now targeting its work to serve people vulnerable to lung disease and families with asthmatic children —particularly people of color, low-income residents, immigrants and refugees, as well as neighborhoods with high asthma rates. Also, MHE has hired bilingual CC members.	Without City funding, the program would be discontinued. Without City funding, at least 200 Seattle families would not benefit from a Home Environmental Assessment List (HEAL) in-home evaluation and make changes to eliminate in-home toxins and asthma triggers and to improve indoor air quality. Also many other would not benefit from MHE education and information.	**a) Evidence-based/promising practices –** Studies of the MHE program have found that the majority of households reported making behavioral changes and implemented at least one recommendation to improve air quality. **b) Culturally competent –** The HEAL home assessment is now offered in Mandarin, Cantonese, Vietnamese and Arabic as well as English. MHE has made changes in order to target its services to high-need families and neighborhoods. **c) City funding –** City funding is critical and without it, MHE services would not be provided. ALAWA raises $57,797 to supplement the City's funding. **d) Cost effective –** Costs are reasonable and include 10% for administration. **e) Administratively efficient –** City funding is essential to the program; administrative costs are reasonable. The City's investment is $58,000. **f) Track and report outcomes –** HSD has worked with ALAWA to change how it tracks and reports outcomes.	MHE meets the HCI policy framework criteria. It is an evidence-based program that studies suggest leads to behavioral changes to improve indoor air quality. Program Direction: 1. Continue the new focus of targeting services to high-need families and neighborhoods. 2. Bring in more CC members to offer the HEAL assessment in additional languages. Work to recruit and train bilingual volunteers. 3. Partner with community organizations in order to outreach and better serve diverse communities. (e.g., Refugee Women's Alliance, Seattle Urban League) 4. Consider combining the funds from this project and the Public Health Department's Indoor Air Quality program and conduct an RFI process.

Without GF, does Seattle Receive its Fair Share?	Criterion 1: Goal Alignment	Criterion 2: Addresses Need	Criterion 3: Addresses Disparities	Criterion 4: Outcomes	Criterion 5: Sound Practices	Summary Recommendation
African American Elders Program (AAEP) Nurse (Contractor: Catholic Community Services [CCS])						
Yes – This is an enhanced service that would not be provided without City funding. City funds provide a full time community nurse to work as part of the African-American Elders Program, which provides case management and support to frail African-American older adults.	**Goal 1:** Eliminate disparities – The program is focused on serving homebound African-American older adults. **Goal 2:** Promote access – The AAEP nurse assists people in accessing the health services they need. **Goal 4:** Supports the City goal of healthy aging by helping clients to manage their chronic conditions and to connect them to community resources and health promotion activities.	The AAEP Nurse serves the most medically unstable and fragile clients with chronic health conditions who need ongoing interventions to maintain a stable health status. African-Americans are disproportionately affected by such chronic conditions as diabetes, asthma, obesity, and heart disease. The AAEP nurse helps to manage and prevent these conditions by providing case management and nursing services.	All clients served are African-American older adults who are disproportionately affected by chronic health conditions. They are homebound and medically fragile. By providing culturally appropriate health services, the AAEP nurse helps clients to continue to live at home, manage their chronic conditions, and avoid costly medical interventions.	This is a 'new' program and HSD is working with CCS to develop a baseline for health outcomes and to monitor program effectiveness. Until several years ago, a Public Health Nurse provided these services very effectively. Without City funding, 175 older African Americans, with serious health conditions, including 75 with who are medically fragile, would not receive the support they need to manage their chronic conditions and live fuller, healthier lives.	**a) Evidence-based/promising practices –** The program conforms to standard case management and nursing services protocols established by the State DSHS Aging and Disability Services Administration. **b) Culturally competent –** CCS actively trains staff in cultural competence. AAEP staff members are African-Americans. **d) Cost effective –** The program is cost effective considering the un-necessary hospitalizations, emergency room visits and early institutionalization into nursing homes that the program prevents. **e) Administratively efficient –** This funding and program are administered by HSD Aging and Disabilities Division. The funding for the nurse is part of the overall African-American Elders Program that HSD contracts with CCS to operate. **f) Track and report outcomes –** HSD is working with CCS to develop the outcome measures for this program. Current program outcomes include decreasing the percent of people whose health interfered with their activities; increasing the percent of people who have a usual source of health care; increasing the percent with adequate assistance in their daily activities.	This is a new program that HSD will be working with closely. It meets all of the HCI policy framework criteria and addresses disparities by focusing on African-American older adults who disproportionately suffer from chronic health problems. Program Direction: 1. Develop appropriate health outcome measures. 2. Integrate the nurse role into the AAEP team.